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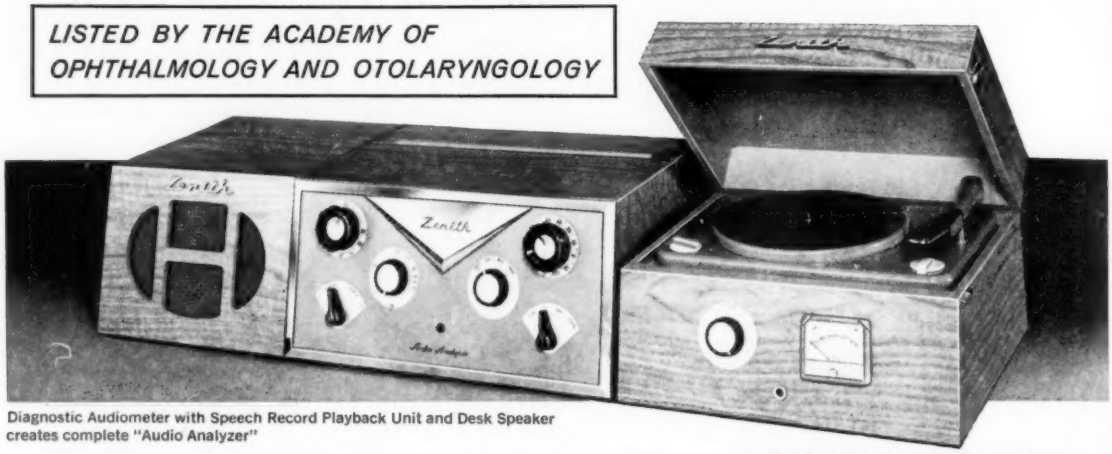

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ARE SPEECH DISORDERS 'SUPERFICIAL' OR 'BASIC'?

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FROM clinical and laboratory work with speech disorders we gain a heightened sensitivity to the problems human beings have with the only bodily function that sets them apart from their furry, feathered, and scaly fellow creatures. We might almost be pardoned for giving way to the conclusion that man acquired speech before he was quite ready for it. Now that he has it, he doesn't seem able to make it work the way it should. An impressive variety of things appear to go wrong with it, and, paradoxically, one of the most remarkable facets of man's linguistic development is to be seen in the burgeoning vocabulary with which he complains ever more painstakingly about the trouble he has in communicating. For every word man has coined to speak well of speech he has concocted a score or more to deprecate and diagnose it.

And yet, it is precisely in the speaking we do about the speaking we do that we seem to misuse most lamentably the gift of symbol. Our greatest need is for more adequate language about language.

MAN'S SYMBOLIC UNIQUENESS

Mostly we talk about our talking selves as though we were not symbol-creating and symbol-using creatures at all, but as though we were, rather, brother to the rat, not yet descended—or ascended—from the chimpanzee. Our basic attitude toward words is, largely and commonly, that they are *mere* words. We are far more likely to say that we use language merely to express our thoughts than we are to take for granted that it is our language that puts words in our mouths and ideas in our heads and pretty much does our thinking for us. Most of us, indeed, talk as though we were innocent of all suspicion that the language we are using has anything to do with what we are saying. We talk ourselves into despair—and deepen it by telling ourselves that, naturally, we can't help how we feel.

Even Sigmund Freud, for all his creative sensitivity to the curative and life-shaping influence of talk, approached neurolinguistic and semantic issues somewhat coyly and indirectly. Fascinated as he was by symbolism, he seemed to regard the essentially animal level of instinct and libido as more "basic." And nearly all of us have yet to gain the equivalent of Freud's appreciation of the role of language and speech in the motivation and patterning of behavior. This seems all the more remarkable when viewed against the fact that for so long a time we have had, besides Freud, the examples of Charles Sanders Peirce and Karl Pearson, Ludwig Wittgenstein and Alfred Korzybski—to say nothing of Jonathan Swift and Lewis Carroll—and an ever growing company of other men and women, many of them in our own profession, whose keen sense of symbol becomes keener with ever more knowing cultivation. In the light of their influence, any attempt to distill and interpret the uniqueness of man that does not involve substantial or major emphasis on the symbolization process seems anachronistic.

ON TREATING "THE WHOLE PERSON"

One of the more striking illustrations of devaluation of the symbolization process in relation to behavior and to health and distress is the widespread view that speech disorders are symptomatic—*merely* symptomatic—of other conditions that are said to be "more basic" and "deeper." It appears to be commonly taken for granted that stuttering, for example, is a symptom of some underlying emotional instability, or personality maladjustment, or psychoneurosis. It is a respected corollary of this assumption that speech disorders are symptomatic of disturbance of "the whole person." It is assumed to follow that it is "the whole person," rather than the speech disorder, as such, that is to be treated. The syllogistic chain reaction thus set in motion leads automatically to the conclusion that the "treatment of choice" for speech disorders is psychotherapy, since psychotherapy is assumed to be distinctively suitable for treating "the whole person."

This scaffolding of premise and deduction having been erected, its builders find it useful as a platform from which to launch kites of therapeutic caution and prescription. Concern is expressed with respect to so-called symptom-centered therapy of any kind. Various clinical procedures which are focused upon analysis and relearning of the affected aspects of speech behavior are condemned as superficial therapy. Questions are raised as to whether any patient should be treated by a clinician who is not trained or disposed to treat what is referred to somewhat ambiguously as "the whole person."

Given certain definitions of "the whole person," these warnings would appear to be directed by implication to a substantial proportion of all that is done by physicians and surgeons as well as teachers and other members of "the helping professions." Is it "the whole person" that is being treated when an appendectomy is performed, or a nasal spray is administered, or a change of diet is prescribed for a heart patient?

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Is it "the whole person" that is in the focus of attention of the teacher of chemistry, the vocational counselor, or even the psychiatrist in clinical conference with a depressed sales executive?

In what precise senses of "whole," "person," and "treated" might "the whole person" be "treated"? It could be that by "the whole person" is meant that which any clinician or teacher unavoidably affects somehow by undertaking anything in the name of therapy or instruction, in accordance with the principle that anything is related to everything else. If the meaning intended is of this order, it is to be appreciated that a considerable improvement in the ability to communicate through speech probably affects "the whole person" more than do most other forms of "treatment." Ruesch and Bateson (*9*) present the view that "disturbances of communication . . . are directly or indirectly responsible for disturbances of behavior," and they develop the thesis that correcting impaired processes of communication, so far from constituting a "symptomatic approach," is basic even in profound psychotherapy. Weighed against such considerations as these, the view that clinical speech services are necessarily "symptomatic therapy" would appear to be derived from the assumption that the functions of speech and language play only a superficial role in the bodily economy and in the covert and overt behavior of "the whole person." The validity of this assumption would seem to be doubtful.

To anyone who may be disturbed about speech clinicians who do not seem to "treat the whole person," there is to be recommended an additional worry about clinical workers in any field who, whether or not they intend to "treat the whole person," give scant attention to the speech and language functions of the patient. It is to be observed with mingled reassurance and dismay that thoroughly trained speech pathologists are likely, of necessity, to know a good deal about neurology, physiology and psychology, but it seems to be somewhat less certain that formally qualified neurologists, physiologists and psychologists are likely to know very much about speech pathology. The emphasis given in the better programs to the biological, behavioral and social sciences in the training of speech pathologists is heartening. In the best interests of all concerned, it is to be hoped that attention will be given increasingly to the study of the symbolization and communication processes and their disorders in the training of physicians, psychiatrists, psychologists, and the members of the other helping professions.

WHAT ARE SYMPTOMS SYMPTOMS OF?

These considerations would seem to be of particular significance to workers directly or indirectly concerned with psychotherapy and counseling in its various forms. It appears to be widely accepted that the effectiveness of psychotherapy and of counseling in various fields depends upon, and is reflected in, the adequacy of the communicative interaction between clinician, or counselor, and the person being served. One of the more obvious experimental and clinical approaches to the investigation of this interaction and to the exploration of its possible improvement is that of the professional worker who is intensively concerned with the causes, characteristics, and effects of impaired language and speech.

One of the more important observations to be weighed in this connection is that while impaired language and speech interact with and affect in more or less distinctive ways the behavior, feelings, thinking and general adjustment of the person, it does not follow that they are generally or distinctively "symptomatic" in the usually accepted medical or psychiatric sense. Certainly no one would seriously assert that speech impairments associated with such organic conditions as cleft palate, cerebral palsy, laryngectomy, or cerebrovascular accident are basically symptomatic of psychoneurosis. What is perhaps less likely to be taken for granted is the well documented view that the problem called stuttering, when closely investigated, does not lend itself readily to classification primarily as a symptom of psychoneurosis, or of "basic" emotional disturbance however designated. On the basis of a comprehensive evaluative review of relevant research, Goodstein (*1*) concluded that children regarded as stutterers have not been shown to be "neurotic or severely maladjusted" and that "there is no general support for the notion that adult stutterers are severely maladjusted or even consistently different from anyone else." In a review of twenty investigations involving the use of projective personality tests, Sheehan (*11*) stated that "no dynamic differences appear between adults who stutter and adults who do not–even by the best tools modern clinical psychology has developed to measure such differences. Moreover, no consistent pattern emerges for the stutterer."

These conclusions are consistent with the findings of research carried on at Iowa for some thirty years. The bulk of the data so far accumulated has been presented in several publications (*4, 5, 6, 7*), and the basic sense of these data is to be summarized briefly in the statement that with respect to personality characteristics and adjustment stutterers are essentially like nonstutterers. "Insofar as they differ from nonstutterers in their personal and social adjustments, some of them are a little more socially withdrawing and a little more inclined toward discouragement. It is a difference, on the average, of about the proper magnitude to indicate that stutterers react to the frustration and humiliation of stuttering with essentially normal effect. . . .

"What is to be added to this generalization is the observation that, while stutterers are like other people in having various reasons for developing maladjustments, the stuttering itself undoubtedly serves in many cases as a source of more or less significant emotional unrest and demoralization. This is not to say that stuttering leads to, or is, a symptom of a

psychoneurosis. It does not mean that stutterers cannot have psychoneuroses of the types other people have. Nor does it mean that psychoneurotic mechanisms cannot in some instances manifest themselves in stutter-like reactions. What it does mean primarily is that, while stutterers by and large appear to be essentially normal as personalities, they, like other people, can and do have adjustment problems, and some of their adjustment difficulties seem to stem from the fact that they stutter" (*6*).

The practical experience we have had at Iowa in referring stutterers to psychiatrists and clinical psychologists would appear to be of particular interest. Our clinical program for stutterers was originally housed, from about 1925 to 1930, in the Iowa Psychopathic Hospital and we worked closely with the staff of the Department of Psychiatry. We attended staff meetings and rounds in Psychiatry, and some of our courses and seminars were conducted by psychiatrists, including among others Drs. William Malamud, Erich Lindemann, John Dorsey, Samuel T. Orton, and Andrew Woods. Naturally under these circumstances many stutterers were referred for psychiatric evaluation and some of our research on stuttering was carried on in collaboration with members of the staff in Psychiatry. Later, Dr. Charles R. Strother and I, after using most of our uncommitted time for many years in counseling students with adjustment problems, succeeded, in cooperation with others who also were concerned, in getting the University to establish a Student Counseling Office staffed with clinical psychologists who assumed official responsibility for the psychological counseling of students with personal problems. Since around 1945 or so we have referred all the stutterers who evidenced notable need for psychological counseling to the Student Counseling Office, and we have continued, as before, to refer those who appeared to be the most seriously maladjusted to Psychiatry.

It is to be estimated that we have referred approximately 5 to 8 per cent of our stutterers to the Student Counseling Office, and it has been our general experience that while the psychotherapy carried out has usually had relatively little effect on the stuttering problem, in many cases the stutterers were influenced by the psychotherapy to apply themselves somewhat more effectively to their programs of therapy in the Speech Clinic.

A good estimate is that we have referred roughly 2 to 3 per cent of our stutterers to Psychiatry; of these, at least 80 per cent have been returned to us with the report that they did not present problems warranting psychiatric attention. These, it is to be emphasized, were the most maladjusted of the stutterers in a well established speech clinic that attracts from throughout the United States and other countries a sampling which includes probably a greater proportion of severe and complicated cases than is characteristic of the general population of stutterers.

The substantial accumulation of research findings reviewed by Goodstein and Sheehan, the relevant clinical and experimental data obtained at Iowa, the diagnostic evaluations made by psychiatrists to whom the more maladjusted stutterers at Iowa have been referred over the past 35 years, and the indicated experience with counseling of stutterers by clinical psychologists, hardly support the view that "psychotherapy is the approach of choice" for stuttering.

SPEECH THERAPY AND PSYCHOTHERAPY

This statement is not intended to imply that there is no value in psychotherapy for a certain proportion of persons who happen to stutter or to have other impairments of Speech. Travis (*12*), *Sheehan* (*10*), Murphy and FitzSimmons (*8*), Hejna (*2*), West (*15*), Van Riper (*14*), and others, including the present writer (*4, 5, 7*), have made clear that psychological counseling and psychotherapy, certainly in some of their general forms and specific applications, are feasible, appropriate, and advantageous for such persons. Indeed, speech therapy, as these and other speech pathologists describe it, includes much that is psychotherapy. Van Riper's introductory textbook, *Speech Correction Principles and Practices*, which is representative of widespread practices in the field, contains a chapter on psychotherapy and reflects throughout a a sophisticated concern for the person whose speech is impaired. A universally accepted statement of principle in this profession is one made many years ago by Lee Edward Travis (*13*): "A speech disorder is a disorder of the person as well as a disorder in the movements of the speech organs. It is not enough to know what sort of a speech defect a person has. In addition, one should know what kind of a person has a speech defect. . . . We are not interested in speech defects, but in speech defectives."

The very purposes for which psychotherapy is commonly carried on are prominent among those that are generally realized through the diagnosis and appraisal of a speech disorder, its analysis and informed re-evaluation, and the remedial speech instruction, systematic practice, and related counseling that make up competent present-day speech therapy. The major consequence of its effective application is more adequate personal and social adjustment. It is by no means obvious where speech therapy leaves off and psychotherapy begins, or vice versa. Even the most "mechanical" speech correction often has profound effects on the personality, because the speech and language functions that are affected by it are basic rather than superficial, and when they are improved personal and social adjustment is changed for the better. In this sense, speech therapy may be regarded indeed as a peculiarly effective form of psychotherapy.

So far as there are kinds of psychotherapy that differ from speech therapy they can sometimes be of particular value to persons with speech impairments for the sorts of adjustment problems, including the psychoneuroses, by which they are beset in their

capacities as human beings, without reference necessarily to their speech disorders. It is generally agreed that roughly one out of every ten of us spends some part of his days in clinical relationship with psychiatrists or clinical psychologists—and undoubtedly many more of us would be well advised to do so. There would appear to be no solid reason to assume that less than a like proportion of persons with impaired speech do, or should, avail themselves of psychological counseling or psychotherapy. One of the reasons why they should do so is that in many cases it can be beneficial to them in relieving certain of the maladjustments occasioned by their less than satisfactory communicative experiences.

SYMBOLIZATION AS BASIC FUNCTION

These things having been said, it would seem to be particularly in order to sound a concluding note of caution concerning the view that stuttering, or any other speech problem, is symptomatic of a disturbance of "the whole person." In the absence of demonstrable evidence to the contrary, there is something to be said for keeping such a speech disorder as stuttering in balanced perspective as a problem that concerns a basically sound person. Until the contrary is established, there are advantages in assuming that this person is capable of understanding what he needs to know and of doing whatever he might do in order to speak less hesitantly, more fluently, more comfortably, and in general to relate to other persons more effectively through the medium of speech.

It is more likely to be harmful than helpful to encourage the person to think of his impaired speech as evidence that he is defective or disturbed as "a whole person." It is to be soberly considered that to be "treated as a whole person" is to be stimulated in some degree to believe that it is one's whole person that needs treatment. Observations to be made of some of the stutterers who have undergone various kinds and amounts of psychotherapy *for their stuttering* strongly indicate that it is wise to be cautious in applying this general type of therapy to this particular problem on the assumption that stuttering is symptomatic of psychoneurosis or significant emotional disturbance in any fundamental sense. To be helped clinically to face and deal with conditions that are real and present is one thing; to be persuaded to become preoccupied with problems that would not otherwise exist is quite a different thing. There is substantial hazard in taking for granted that there is more the matter with the patient than can be clearly demonstrated. In this connection, it is to be thoughtfully recalled that scarcely a hundred years ago prominent European surgeons were removing varying portions of the tongues of stutterers, presumably on the assumption that anything less than surgery could be only symptomatic and superficial therapy.

We can learn from this sort of history and from experience generally. We can learn that speech is not "merely verbal." Speech disorders are not "mere symptoms." We can learn that there may not be anything "deeper" in the person who stutters than the stuttering he does; when a person's one distinctively human function is disturbed, anything else that he may feel, think, or do may very well be symptomatic of that.

We can learn that there is nothing else about a human being "more basic" to his humanity than the gift of symbol, the wonder of tongues, the ever recurring miracle of language and speech.

We can learn that to employ speech therapy to relieve or eliminate the disorders of this most basic of the functions of humanity is to produce effects which are more often profound than superficial. And if it is "the whole person" that is to be transformed, by no other means is this likely to be brought about more effectively than through appropriate change in his symbolic processes and his ways of speaking.

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OPPORTUNITIES FOR CLINICAL TRAINING IN A MEDICAL CENTER SPEECH AND HEARING CLINIC

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In this country the training of audiologists, speech pathologists, and speech and hearing clinicians has been, and still is, largely a function of speech departments of colleges and universities. Generally the training programs, both academic and clinical, have little or no relation to medical education or treatment activity in a medical center. Up to now this situation probably has been good for the field of speech and hearing. In very recent years, however, increasing demand has been felt for speech and hearing services in a wide variety of medical situations including medical school teaching hospitals, private convalescent hospitals, pediatric clinics, Veterans Administration medical facilities, hospitals for the mentally retarded and emotionally disturbed, orthopedic treatment centers, and the rapidly increasing rehabilitation centers.

MEDICALLY ORIENTED CLINICAL TRAINING NEEDED

Perhaps the time has come when the speech and hearing profession must direct its attention toward providing the kind of training in speech and hearing which would enable a much larger number of clinicians to provide services in medical centers. In addition to this need it has become increasingly apparent that individuals working with speech and hearing disorders in any situation need considerably more orientation toward the medical and health aspects of their patients than is the case at present. It must be recognized that a speech, hearing or language disorder severe enough to require the earnest attention of a qualified clinician generally is only a part of several deviations from the normal in the same person. Usually the several deviations, in addition to the communicative disorder, are medical or health problems. In medicine the concept that no one person is capable of diagnosing and treating all of the aspects of a patient's disorder is becoming quite firmly established. It also is recognized that adequate treatment of one particular problem often is meaningless without consideration of other existing problems in relation to the individual as a whole. Recognition of the same concept is necessary with respect to communicative disorders.

In our training in speech and hearing we have given considerable attention to developing an understanding of mental, psychological, and social problems; but those problems falling in the field of health and medicine generally have not received attention in our training programs. For these reasons it is suggested that the speech and hearing clinic located in a medical center offers some significant advantages for clinical training. Such a situation provides a breadth, depth and richness of clinical experience that cannot be possible in any other setting. The advantages of this kind of training apply not only to those who plan to work in medical settings, but also to those who will work with communicative disorders in other kinds of situations. This writer does not suggest that all clinical training should take place in a medical center. Perhaps the ideal would be for a combination of opportunity in both the usual clinic and the medically-oriented clinic.

TREATMENT RELATED TO COMPREHENSIVE EVALUATION AND DIAGNOSIS

A primary advantage for clinical training in a medical center is that such a center provides ample opportunity for treatment of the communicative disorder to be planned and carried out in terms of a definitive, comprehensive evaluation and diagnosis and in relation to treatment of the patient's other problems. Too frequently in many clinics, treatment must be carried out in isolation from therapeutic treatment of the patient's other problems, which may be in addition to or primary to the communicative disorder.

The longer one works with communicative disorders, and observes the treatment we offer for these disorders in schools and speech and hearing clinics, the more one is impressed that much time and energy is wasted because of failure to know the specific nature of the communicative disorder, related disorders, and other aspects before a plan of treatment is set up and put into execution. When the student in training can observe a complete pediatric work-up of a child with a communicative disorder and have the results of such an examination; when he can observe and use the neurological examination, that done by the otolaryngologist, the psychiatrist, the medically-oriented psychologist, and perhaps the orthopedist—he has a much better opportunity to understand the total child with the communicative disorder, as well as the disorder itself. He has a base upon which to plan his own treatment. With such opportunities, he can learn to make judgments which, in many cases, may eliminate the necessity for his entering the therapeutic picture at all. With such an orientation in his clinical training, he will not then, regardless of the situation in which he works, proceed with a quick inventory of a speech "case" and begin treatment much in the same

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manner that he has begun treatment of the hundreds of others before this one.

SPEECH THERAPY RELATED TO OTHER TREATMENT

The second advantage of a medical center training program is that the student has the opportunity to learn to carry out his treatment in conjunction with other therapeutic procedures; and can either work in a supportive manner or can organize other treatment in support of his own, depending on the nature of the problem. Therapy for the child with cerebral palsy, for example, is quite meaningless unless the speech clinician can work very closely with the physical and occupational therapists involved with the case. If this is not done, treatment frequently is at cross purposes. In a closely integrated medical center, speech training often is given at the same time the child receives occupational or physical therapy; with both speech clinician and occupational or physical therapist being present and coordinating their efforts. To the student in training this kind of cooperative therapeutic endeavor is invaluable experience.

The child whose communicative disorder is associated with a cleft palate presents speech problems that cannot be dealt with in isolation from the rest of his treatment. The medical center allows the speech clinician to observe and participate in plastic procedures, and in such treatment as construction and training for use of a speech bulb prosthesis, or orthodontia. Speech training frequently is quite meaningless unless it is planned and executed in terms of the other treatment that is being given, has been given, or will be given.

The communicative disorder arising from aphasia is not just a disorder of speech and language, it is a disorder of the entire mechanism, and proper treatment involves the entire mechanism. It may well be that training in the speech and language areas must be done in cooperation with psychotherapy, neurological treatment, or physical or occupational therapy. The hard of hearing child may have a communicative disorder directly related to the hearing loss, or it may be related to other things. Training in speech will become much more effective if it is done in collaboration with treatment being given by the otolaryngologist or other specialist. A child undergoing psychiatric treatment may well have a major communicative disorder. Speech training apart from the psychiatric treatment not only may be useless, but could be disastrous.

The above list could be extended, but it becomes obvious that the student trained to a high degree of awareness of the need for other specialties and ways in which to integrate the speech and language treatment with other kinds of treatment, will be a much more competent clinician than the one who never has this experience. A person so trained may well spend a good part of his time in consultation with, and observation of, the doctor, the dentist, the psychiatrist, the psychologist, the physical therapist, the occupational therapist, the social worker and others. His case load may be considerably smaller than it otherwise would, and the road to more adequate communication for his cases may be much shorter.

WIDE VARIETY AND SEVERITY OF CASES

A final advantage that the medical center offers in clinical training is that it provides an unusual variety of types of problems, severity, and range in age of clinical teaching cases. Prior to coming to his present position, the writer directed a speech and hearing clinic in a large State Teachers College. This clinic offered training to from ten to fifteen speech correction majors each year, and probably was quite typical as to problems that came to the clinic, the selection of kinds of teaching cases, and opportunities for clinical experience. In the two years just prior to leaving that situation, students in the clinic had opportunity to see only one child with a cleft palate, two children with cerebral palsy, one laryngectomy, no adult aphasics, and a few voice cases. Clinical training was given with the usual large number of articulatory problems—most of them college students who showed minor deviations, and minor and severe delay cases which were accepted for treatment with the most inadequate kind of evaluation and diagnosis.

In the past year 1360 patients were seen in the clinic which the writer presently directs in a medical school. These patients are screened before being accepted in such a manner that not one case of the 1360 could be considered a minor problem—if there is such. All were severe, and many showed a number of related anomalies and problems. The speech and hearing disorders covered every conceivable kind that could come to such a clinic. Among these were approximately 300 children with cleft palate, 700 with cerebral palsy, 200 with speech and language problems due to neurological dysfunction other than cerebral palsy, and a number of problems due to emotional disturbance and other causes. In addition to these cases coming to the clinic, a wide variety of adult problems were evaluated in the various other hospitals and clinics of the medical school.

Available to the speech clinician in this clinic are all of the resources needed in the medical school. If the problem warrants it, and many of them do, the child is examined and staffed by as many as 10 different specialists representing that many different specialties; and then this group, including the speech and hearing clinician, meet together as a team to determine a diagnosis and a plan of treatment. This kind of situation is available for the training of speech and hearing clinicians. The entire range of therapeutic approach, technique and skill may be demonstrated to, and used by, the student in training in such a situation.

Because of the wide variety of kinds of problems and sources from which the patients come, the student also has opportunity to learn of, and learn

how to work with, many different community agencies. Referrals to this kind of a clinic come from public health departments, child guidance clinics, child development centers, public schools, special education departments, other speech and hearing clinicians, physicians, dentists, and many others. Learning how to request information from these various sources, how to receive a referral, how to use the information, and to report back are of tremendous importance. Learning the nature of these agencies and how to work with them is of considerable importance. It is not uncommon at this center, for example, when a case has been referred by a school clinician, for the clinician to attend some of the examinations and the staffing; at which time he will sit with a diagnostic team composed of some combination of the following specialists: the pediatrician, orthopedist, neurologist, psychiatrist, otolaryngologist, orthodontist, prosthodontist, psychologist, physical therapist, occupational therapist, social worker, the child's classroom teacher, perhaps his school principal, and not infrequently the family physician. If another agency is involved, such as a child guidance clinic, health department, or nursery school—representatives of this agency also are likely to be present. A student in training has opportunity to hear all of these people, to learn of their ways of thinking, some of the aspects of their particular agencies and functions, and how they relate to his specialty.

SUMMARY OF MAJOR ADVANTAGES

In summary, we see three major advantages for student training in speech and hearing in a medical center. These are: (1) The opportunity for the student in training to learn of the many various aspects, implications, and methods of evaluation and diagnosis of the whole person rather than just a single disorder. The opportunity, further, to build his plan of treatment on the basis of such an evaluation and diagnosis. (2) The opportunity for the student in training to carry out treatment procedures for the communicative disorder in conjunction with other kinds of therapeutic procedures that may be taking place at the same time. (3) Opportunity for a wide range of experience with every kind of speech and hearing communicative disorder that one ever will see in his clinical practice.

THE PREPARATION AND USE OF SLIDES FOR THE ASHA CONVENTION

Following the 1960 Convention the Program Committee surveyed more than 400 of our members who frequently make public presentations. Approximately half of those responding to the questionnaire indicated that they typically use slides in the presentation of materials. Accordingly the Program Committee decided that the use of slides should be permitted. They hoped, however, that slides would be used judiciously and only for those presentations which would be more effective as a consequence. This note is presented in an attempt to remind the users of slides of their responsibilities in this matter of choice and to suggest these simple rules for the preparation of slides:

1. Use a slide only if it will clarify or emphasize a point.
2. Present only one idea on a slide.
3. Plan every slide so that it can be read and comprehended rapidly. (Most slides are on the screen for less than a minute.)
4. Omit every unnecessary word, line or number.
5. Avoid clutter, being mindful that the value of the slide depends on the impact of a visual image.
6. If tables must be used, limit them to four columns (two are better) and 10 lines. Avoid masses of data.
7. Keep headings brief, listings short, numbers rounded and at a minimum, drawings and wording simple.
8. Choose the kind of drawing best suited to convey your information: many professionals advise use of line graphs for indicating trends, bar graphs for comparing magnitudes, and pie graphs for showing portions of a whole.
9. Have slides prepared by professionals if possible.
10. When professional services are not available and when the slide must be made by photographing graphs, drawings, charts, and/or typewritten copy.
    a. make sure that all lines are clear and true;
    b. use mechanical lettering sets or type in all lettering rather than trying to do it by hand;
    c. double space all typewritten copy including tables;
    d. capitalize principal words in titles but otherwise use lower case letters;
    e. never try to get more than half of an 8½" x 11" page of typewritten copy on one slide (less is better).
11. For additional information on choice of material and preparation of slides see *Illustrations for Publication and Projection*, ASA Y15.1-1959, The American Society of Mechanical Engineers, 29 West 39th Street, New York 18, New York, or Tribe, H. E. "Effective illustrations for the presentation of papers," *Journal of Plastic and Reconstructive Surgery*, 25, 1960, 265-273.

The writer is indebted to Gloma Rosenthal, Medical Illustrations, and to Dorothy W. Moeller, Assistant to the Editor, *JSHR*, University of Iowa for suggestions in the preparation of this note.

D. C. Spriestersbach, Program Chairman

SHORT COURSES

37th ANNUAL ASHA CONVENTION

Eight short courses are to be included in the richly promising 1961 Convention Program to serve more adequately the varied professional needs and interests of the membership of ASHA. This is the first year in which the Association will offer a group of short courses as part of the Convention. Two courses in audiology and two courses in speech pathology will be offered concurrently from 9:00 A.M. to 1:00 P.M., on Sunday, November 5. Two more courses in each area will be offered from 1:00 P.M. to 5:00 P.M. on Wednesday, November 8. Individuals of established competence in our profession have agreed to teach these courses. An enrollment fee of $5.00 will be charged for each course. The instructors will receive a stipend for their services. No formal credit will be given for the courses.

Any member can register for as many as two courses, one on Sunday, November 5, and one on Wednesday, November 8. Pre-enrollment for the short courses is encouraged. Enrollment is not open to undergraduate students. The demand for these courses is expected to be heavy and placement will be made on a first come, first served basis. Therefore, anyone interested in attending a short course is advised to apply now. If some places still remain unoccupied at Convention time, they will be made available at the Convention.

A list of the instructors and a brief description of the short courses follows:

THE MANAGEMENT OF THE HARD OF HEARING CHILD IN THE SCHOOLS

Charlotte B. Avery, Associate Professor of Audiology, University of Pittsburgh, School of Medicine, Pittsburgh, Pennsylvania.

Criteria for pupil selection; appropriate school placement. Curriculum and course of study. Methods and materials for language training (receptive and expressive), auditory training and hearing aid orientation, teaching of school subjects. Orientation for the regular classroom teacher. Criteria for termination of special handling or special class placement.

HEARING-AID EVALUATION

Raymond Carhart, Professor of Audiology, Northwestern University, Evanston, Illinois.

Review of philosophies of hearing aid selection; assessment of techniques for gauging a patient's need for a hearing aid and for evaluating his performance with wearable amplification; survey of the limitations and advantages resulting for the patient because of the construction and performance of contemporary hearing aids, including implications for use of binaural hearing aids.

RECENT DEVELOPMENTS IN AUDIOLOGICAL MEASUREMENT

James Jerger, Associate Professor of Audiology, Northwestern University, Evanston, Illinois.

Consideration of the theory and practice of newly devised audiologic techniques for diagnostic audiometry. Use of SAL, SISI, SWAMI, distorted speech tests, Békésy audiometry, and loudness balance tests in assessing auditory function.

CLINICAL COUNSELING

Wendell Johnson, Professor of Speech Pathology and Psychology, University of Iowa, Iowa City, Iowa.

This is a course for professional workers in speech pathology and audiology. It is designed to cover in a general way the principles and procedures of clinical couseling as represented mainly by current practices in psychiatry and clinical psychology and in a somewhat more detailed fashion the particular kinds of counseling that are most appropriate in speech and hearing clinics. Special consideration will be given to the interaction of the symbolization process and other bodily functions and aspects of personality, and to the fundamental question of whether disorders of communication are superficial symptoms of personal and social maladjustment or causes of such maladjustment. On the basis of these basic considerations, principles and procedures of counseling in speech and hearing clinics will be elaborated. Illustrative samples of tape recorded counseling sessions will be used so far as this proves to be feasible.

ARTICULATION TESTING AND TREATMENT

Eugene T. McDonald, Professor of Clinical Speech and of Speech Education, Director, Speech and Hearing Clinic, Pennsylvania State University, University Park, Pennsylvania.

An integration of research and clinical observation to describe articulation as a product of dynamic processes. Plan for diagnosis and therapy based on this point of view, including description of a deep test of articulation with discussion of implications for research and clinical treatment.

THE ASSESSMENT AND TEACHING OF APHASIC CHILDREN

Mildred McGinnis, Director of the Division of Speech Correction and Pathology, Central Institute for the Deaf, St. Louis, Missouri.

A presentation of the differential diagnosis of children having various language disorders with emphasis on the concept of aphasia in children developed at Central Institute. A presentation of the principles of the CID-McGinnis method for teaching aphasic children.

ADVANCED AUDIOMETRY

Hayes A. Newby, Professor of Speech Pathology and Audiology, Stanford University School of Medicine, Palo Alto, California.

Testing procedures utilized in the audiology clinic: speech audiometry, a review of standard pure-tone testing procedures including the use of masking, interpretation of pure-tone and speech results, special tests for nonorganic problems and for differential diagnosis of sensorineural impairments, and techniques for use in evaluating the hearing of young children.

THE MANAGMENT OF STUTTERING

Charles Van Riper, Director, Speech and Hearing Clinic, Western Michigan University, Kalamazoo, Michigan.

This course is intended to present a review of current practices in the treatment of stuttering, the problems encountered in their administration and the newer techniques available.

A pre-enrollment blank is provided (on green page 248). Return the completed blank with your check or money order for $5.00, if you plan to take one course; or $10.00 if you plan to take two courses. Application for pre-enrollment must be made by October 13. It is highly likely that the enrollments will be completed before that date, so interested persons are advised to enroll as soon as possible.

If a change of plans necessitates withdrawing from the course after enrolling, a refund of the enrollment fee will be made only if the ticket is returned to the National Office within seven days prior to the Convention. A request for a refund must be in the National Office by October 27, if it is to be honored.

SHORT COURSE INSTRUCTORS
37TH ANNUAL ASHA CONVENTION

Charlotte B. Avery

CHARLOTTE B. AVERY, M.A. 1947, Northwestern University, Associate Professor, School of Medicine University of Pittsburgh; Assistant Director, Department of Audiology, Eye and Ear Hospital, Pittsburgh, Pennsylvania. Formerly Principal of Classes for the Deaf, Oshkosh, Wisconsin, Demonstration Teacher of deaf and hard of hearing children, Northwestern University; Critic teacher for teachers in training in Education for the Deaf, Eastern Michigan State College, Ypsilanti, Michigan. Author "Education of Hearing Impaired Children" in Cruichsbank and Johnson's *Education of Exceptional Children and Youth.*

Raymond Carhart

RAYMOND CARHART, Ph.D. 1936, Northwestern University; Head, Audiology Department, Northwestern University; Fellow, American Speech and Hearing Association; American Board of Examiners in Speech Pathology and Audiology (Director Chairman of the Education and Training Board); Fellow, Acoustical Society of America; Committee on Hearing, National Research Council; Armed Forces–National Research Council Committee on Hearing and Bio-Acoustics; Communicative Disorders Research Training Committee, National Institute of Neurological Diseases and Blindness; Holder of numerous consultantships; and recipient of many professional awards. Prodigious research in speech pathology, experimental phonetics, audiometry, and all areas of audiology.

James Jerger

JAMES JERGER, Ph.D. 1954, Northwestern University; formerly Director of the Auditory Research Laboratory at Northwestern University and now serves as Director of the Auditory Research Laboratory, Veteran's Benefit Office, Washington, D. C. At the same time he is Research Professor of Audiology, Hearing and Speech Center, Gallaudet College. Member American Association for the Advancement of Science, Acoustical Society of America, and Fellow, American Speech and Hearing Association; Associate Editor, Journal Speech and Hearing Research; Associate Editor, Journal of Auditory Research; Member Executive Council, American Speech and Hearing Association; Consultant to a number of professional and federal organizations; and author of numerous publications in audiological research.

Wendell Johnson

WENDELL JOHNSON, Ph.D. 1931, University of Iowa; Professor of Speech Pathology and Psychology, University of Iowa, combined major in Speech Pathology and Clinical Psychology, minor in Physiology; Past President and Fellow, Chairman, Publications Board, ASHA; Fellow, American Psychological Association and Diplomate in Clinical Psychology; American Board of Examiners in Professional Psychology; Past President, International Society for General Semantics and Fellow, Institute of General Semantics; Instructor of Iowa courses entitled "Introduction to Speech Pathology and Audiology," "Clinical Counseling in Speech and Hearing," and "General Semantics"; Author of *People in Quandaries, Your Most Enchanted Listener, The Onset of Stuttering, Stuttering and What You Can Do About It,* and *Speech Handicapped School Children* (Co-author and editor), etc.

Eugene T. McDonald

EUGENE T. MC DONALD, Ed.D. 1942, Pennsylvania State University; Director of the Speech and Hearing Clinic; Professor of Clinical Speech; Chairman Speech Education Section, Pennsylvania State University; Fellow, American Psychology Association; Fellow, American Speech and Hearing Association; Past President, American Association for Cleft Palate Rehabilitation; Members American Academy for Cerebral Palsy; and other professional and honorary societies; Consultant in Speech Pathology and Psychology to the National Office for Crippled Children and Adults and several hospitals and treatment centers: author of numerous professional articles; author of the pamphlets *About Children with Cleft Lips and Cleft Palates: A Guide for Parents,* and *Your Child with Cleft Lip and Cleft Palate,* and the book *Understand Those Feelings: A guide for Parents with Handicapped Children and Everyone Who Counsels Them.*

Mildred A. McGinnis

MILDRED A. McGINNIS, M.A. 1939, Washington University, St. Louis, Missouri; Director of the Division of Speech Correction and Pathology at Central Institute for the Deaf; Assistant Professor of Psychology at Washington University and the Dental School of Washington University. McGinnis' professional life has been devoted to the diagnosing and teaching of Aphasic children. She lectures on Speech Pathology and Aphasia in Children and on the method she pioneered for teaching these children. Fellow, American Speech and Hearing Association and member of other speech societies.

Hayes A. Newby

HAYES A. NEWBY, Ph.D. 1947, State University of Iowa, Professor of Speech Pathology and Audiology, Stanford University School of Medicine, Palo Alto, California. Fellow and member of the Council of ASHA, with advanced certification in both hearing and speech. Director and Secretary-Treasurer of ABESPA, and member of Board of Examiners in Audiology. Consultant in Acoustical Audiology to the Veteran's Administration. Author of *Audiology.*

Charles Van Riper

CHARLES VAN RIPER, Ph.D. 1934, University of Iowa; Professor of Speech and Director of Speech and Hearing Clinic, Western Michigan University; Fellow, American Speech and Hearing Association. Associate Editor 1939, JSHD; Councilor 1950-52. Author of *Speech Correction: Principles and Methods; Speech Therapy; Speech in the Elementary Classroom; Teaching Your Child to Talk;* and *A Casebook in Speech Therapy.* Co-author of *A Casebook in Stuttering; Introduction to General American Phonetics; Articulation and Voice: Abnormal and Normal; Stuttering, A Symposium;* and *Voice and Articulation.* Contributor to professional periodicals including the *Quarterly Journal of Speech* and the *Journal of Speech and Hearing Disorders.*

Members of the Committee on Short Courses are:

Frederic Darley	Bruce M. Siegenthaler
Betty Jane McWilliams	Ira J. Hirsh, Chairman

FEDERAL CONSULTANT IN SPEECH AND HEARING

Hope the Anchor of Life—Spes Anchora Vitae—is the motto of the Department of Health, Education, and Welfare. The principle of equality of opportunity is the anchor of hope for handicapped individuals and the Office of Vocational Rehabilitation is charged with making that principle a reality for our disabled citizens.

Raymond Summers

The legal basis for the program of the Office of Vocational Rehabilitation is the Vocational Rehabilitation Act of 1954 (Public Law 565, 83d Congress) which was designed to improve and expand the Nation's resources for restoring disabled persons to productive employment. The actual provision of services for handicapped individuals involves both the States and the Federal Government working on a partnership basis. The Federal Government administers grants-in-aid and the States employ rehabilitation counselors and other personnel who arrange for the needed services, as well as provide counseling and placement services. Public Law 565 encourages the expansion of rehabilitation facilities, authorizes training programs to meet the existing shortage of professionally qualified rehabilitation workers in all fields, and opens the way for public and voluntary nonprofit organizations to obtain financial aid for research and demonstration programs designed to provide solutions to vocational rehabilitation problems.

Raymond Summers is employed by the Office of Vocational Rehabilitation in the Division of Training, the Division that assumes responsibility for the evaluation of applications and award of grants in medicine, nursing, occupational therapy, physical therapy, prosthetics and orthotics, psychology, rehabilitation counseling, social work, and speech pathology and audiology. Summers is the consultant in speech pathology and audiology and as such is the professional person representing the interests of our profession.

To increase the number of speech pathologists and audiologists, in order that more people can be vocationally rehabilitated, it is anticipated that in the 1961-62 academic year the Office of Vocational Rehabilitation will award 38 grants to educational institutions and will provide graduate traineeships for approximately 221 graduate students who have indicated an interest in the rehabilitation of speech and hearing impaired adults.

Current criteria for approving training grants provide that: (1) The institution must have an established curriculum at the graduate level in speech pathology and/or audiology and offer the required coursework to enable students to qualify for advanced certification in the American Speech and Hearing Association; (2) the faculty must be qualified to supervise students being trained for advanced certification; (3) the program must provide students with clinical experiences with adults who manifest the more common communication impairments.

In selecting educational institutions to receive training grants, the OVR is guided by the recommendations of an advisory panel which is composed of leaders in the field. The panel not only reviews and evaluates all applications for training grants but also makes recommendations regarding policies governing grants and the long-range direction of the training program. OVR also maintains a close relationship with ASHA regarding criteria for approving training programs and regarding the general scope and direction of education for the profession.

The selection of trainees for the OVR program rests with the program directors and application information regarding traineeships may be secured from them. In general, traineeships may be awarded to individuals who meet the following eligibility requirements:

They must have been admitted as full-time graduate students to training programs in speech pathology and/or audiology;

They must be interested in future work in the rehabilitation of adults handicapped by speech and hearing impairments;

They must be citizens of the United States or have been lawfully admitted for permanent residence;

They must not receive other Federal educational funds during the period of the OVR traineeship.

Summers completed his undergraduate work at Manchester College, North Manchester, Indiana in 1948. He completed requirements for the M.A. degree at Indiana University in 1952 and earned his Ph.D. degree at Purdue University in 1955. From February 1955 through June 1959. Summers was employed as the Speech and Hearing Administrator, Division of Maternal and Child Health, Indiana State Board of Health.

Sounding Board

News of Interest in the Field of Noise Control

Thousands of IAC Audiometric and Medical Research Rooms Selected for Valid Assessment of Hearing Levels

IAC Rooms have provided "controlled ambient conditions" for industrial and clinical testing as well as for medical research programs of all types.

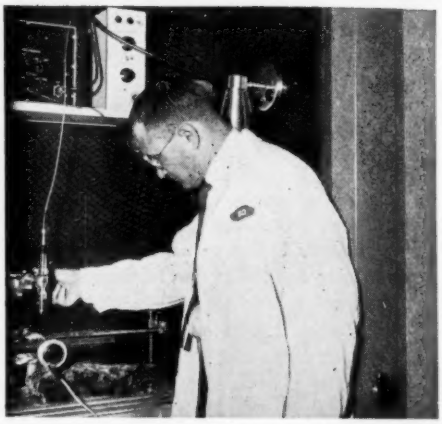
Valuable in "Threshold of Hearing" Research

IAC Rooms offer similar environments for consistent and valid measurements which can be verified in every installation. These controlled environments have made possible research in the successful establishment of hearing norms of young children.

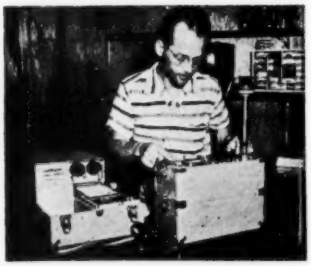
In biological research, standard IAC Rooms were selected to exclude extraneous noise in an electrophysiological study of the cochlear microphonics and auditory nerve action potentials of cats and guinea pigs as recorded directly from the inner ear in response to sounds of known frequency and intensity.

For Auditory Micro-Electric Studies

IAC rooms provide a controlled environment that excludes extraneous noise and prevents stray electrical fields from affecting instrumentation. Circle 61.

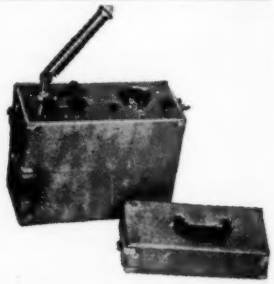


Electronic apparatus installed in an IAC Sound Isolation Room measures the effects of drugs on the auditory response of cats.



Sound Analyzer Also Calibrates Audiometers

The new Rudmose R.A. #100 Sound Analyzer designed for measurement of noise and its analysis is also equipped with an earphone coupler for fast and simple checking of accuracy of calibration of audiometers. As shown in the photograph, the earphone coupler (attached to the Sound Analyzer microphone) transmits audiometer signals into the analyzer for checking. Circle 62.



New literature available:

Information on construction of complete Audiology Clinics, Research Centers. Circle 63.

Complete Data on Hearing Conservation Programs. Circle 64.

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State Associations

ACROSS STATE LINES

The April, 1961, spring conference of the Oklahoma Speech and Hearing Association featured appearances on the program by two out-of-state speech and hearing people. June Miller, of the University of Kansas, and Robert Milisen, of Indiana University, held prominent places on the program. In addition, a scheduled part of the convention was an opportunity for members of the Association to talk informally with these visiting speakers.

WASHINGTON SPEECH AND HEARING ASSOCIATION

The Washington Association held its annual meeting in Tacoma, April 14 and 15, 1961. President James A. Carrell and Vice President Duane Anderson planned a program of interest for both the practicing speech clinicians and those more interested in the theoretical aspect of the profession. Of special interest to those around the country who know her, a luncheon honoring Elvena Miller on the occasion of her retirement as director of the speech and hearing services of the Seattle Public Schools was held. Miller founded the speech correction program in Seattle and has long been recognized as a pioneer, outstanding contributor and leader in the area of public schools speech and hearing services. She plans to travel for awhile after her retirement and then return to Seattle to live. Her successor has not yet been named.

TEACHER CERTIFICATION IN MONTANA

On December 17, 1960, the Montana Teacher Supply Committee, a policy making group composed of the Deans of Education from the five units of the University of Montana which concern themselves with teacher training, approved the following:

"Speech and hearing therapists engaged in school services wherein the public schools of Montana shall issue grades or credits in the pupils' school program, must be certified under the regularly established teacher certification requirements in addition to the certification requirements of ASHA. For related school services which do not involve credits or promotion, the Department of Public Instruction will recognize speech and hearing clinicians licensed by ASHA on the basis of professional association standards on file in the Department of Public Instruction."

The sense of this recommendation together with specific certification regulations for various areas of special education were adapted by the State Department of Education in April, 1961. This is the first time that a policy has been made in Montana concerning standards for public school speech and hearing clinicians.

VERMONT SPEECH AND HEARING ASSOCIATION

The Vermont Speech and Hearing Association is in the process of forming a constitution which, when satisfactory to the group, will be submitted for consideration by ASHA. Until this time the organization has been functioning under an interim set of rules not formally consolidated into a constitution. Frank J. Faulk is serving as president of the organization, and Jane Wamboldt is serving as secretary-treasurer.

In addition to becoming affiliated with ASHA, the Vermont Speech and Hearing Association is active in planning an OVR sponsored Institute on the Deaf and Hard of Hearing, and more effective statewide hearing testing and follow-up techniques in the Vermont schools.

Inasmuch as the number of speech and hearing people in the state of Vermont is relatively small, the Association may be admitted to the ASHA House of State Delegates under the rule allowing one-half vote to state associations with less than 25 members.

NEWS OF INTEREST FROM HAWAII

Hawaii, although the newest of our states, is moving forward rapidly in developing speech and hearing services in the schools. Amy Foster, formerly of Western Reserve University, is State Supervisor of Speech Correction. In addition to the supervising of six clinicians on Oahu, Foster flies to the outer islands of Mauii, Molokai, Lanoi, Hawaii, and Kauai at least annually. On these trips she supervises the program and stimulates the professional growth of the clinicians at the various locations.

An annual workshop is arranged to give clinicians an opportunity to meet to hear authorities discuss new developments in the field, and to give speech and hearing clinicians a chance to discuss mutual problems. Merle Ansberry acts as consultant at these workshops.

The Oahu clinicians have a city organization which may develop into a strong state-wide speech and hearing group.

STATE ASSOCIATION GROWTH IN VIRGINIA

At the time of the organization of the Speech and Hearing Association of Virginia three years ago, it

was estimated that there were about 100 professional workers in clinical speech and hearing in Virginia eligible for Association membership. At that time, the organizing committee estimated that as many as 60 or 70 of these people might be affiliated with the Virginia association in the first five years.

However, as of this date the Association membership now is nearly 100.

This unexpected growth in the Association, while due to the diligent labor of the professional people in Virginia, should give heart to other state organizations who are concerned about membership size. This growth is a function of high calibre of professional meetings at state conventions, a strong professional program within the state, the establishment and maintenance of good standards and ethical practices and the presentation of noteworthy publications to members and prospective members.

INTER-PROFESSIONAL MEETINGS IN COLORADO

The Colorado Speech and Hearing Association on March 27, 1961, participated in its annual interdisciplinary meeting with related professional groups. Following a banquet, a program was presented by the Boettcher Evaluation Clinic of Children's Hospital. A diagnostic work-up of a left hemoplegic child was presented and included pediatric, orthopedic, ophthalmological, psycholgical, speech, audiological, physical therapy, occupational therapy, and educational evaluations.

NEXT MEETING OF HOUSE OF STATE DELEGATES

The ASHA House of State Delegates will meet on Saturday, November 4, 1961, just prior to the ASHA convention. This will be the first regular meeting of the House in as much as last year's meetings were concerned with establishing operations of the House, election of officers, and so forth.

It is expected that at least 25 state organizations will have delegates in the House during the 1961 convention. Although most states will have one delegate, several will be entitled to two. In addition, there are expected to be several states having one-half vote represented by a delegate; these are states having organizations with fewer than 25 members.

Although the agenda for the House of State Delegates meetings is not yet final, further attention will be given to operating procedures, liaison with the ASHA Council, ASHA certification and membership standards, recommendations to the Council, and problems arising at the state level.

The exact time and place of the House meetings will be announced as part of the convention program. All meetings of the House are open to Members and Associates of ASHA, but only delegates elected to the House may vote during its deliberations.

True *Hearing "Naturalness"*
never attained in hearing glasses before!

NOW IN THE SLENDEREST EVER RADIOEAR 890 with *Natural Look* from Eye to Ear!

There now are hearing glasses embodying the acoustical quality required for a RADIOEAR hearing aid—yet with cosmetic styling *fully equal* to that of *any* narrow-taper flex temples for eye-glasses alone! They are the totally new, RADIOEAR 890 Hearing glasses.

Their power-increase surpasses all previous, single-temple eye-glass hearing aids available for testing! Their broad, response-range now covers *all* important voice frequencies! Their built-in tone-control provides new "Hearing Naturalness" and intelligibility truly *unique* for such miniaturized instrumentation!

Their fore-temples come in gold, silver, black, brown and gray—with or without (for men) the jeweler's cartouche, hand-engraved design! Their matching rear-temples are designed left and right, for ideal comfort and fit. Even the necessary conductor-tube, with recess behind the ear, is now made almost to "disappear!"

The self-contained, exclusive, RADIOEAR Phone-master enables users to telephone as naturally as if they had no hearing handicap! All applications and fittings are the *fastest* it has been possible to contrive! Most important the famous (also exclusive) RADIOEAR interchangeable chassis *always* permits *immediate, on-the-spot* application and servicing!

We consider this RADIOEAR 890 as superior to other hearing glasses as various RADIOEARS (for nearly 40 years) have been superior to other hearing aids of their time!

We believe this RADIOEAR 890 has a pride-inspiring "Natural Look!"—a slenderness long overdue, but *finally* compatible with the appearance that wearers *justifiably* demand! We believe you'll "share" our "liking" for the RADIOEAR 890!

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Clinical and Educational Materials

PUBLICATIONS

THE IMMEDIATE GIFT, Clarice Pont, David McKay Co., Inc., New York, New York. This novel designed for young adults is concerned with a young woman who "suffering from a speech block" entered the speech and hearing profession with the hope of eventually overcoming her own problem and of helping children with similar problems. This "Youth Today" novel with its two-fold interest of romance and the dedication of a young clinician at work in the organization and administration of a successful public school speech correction program describes comprehensively the challenges of initiating such a program as well as the necessity of obtaining the best possible public and human relationships with the community, school administrators, teachers, and parents in the achievement of effective therapy with children with different types of speech defects.

Note: This book has possibilities for guidance counselors and others involved in the presentation of materials regarding various careers. 216 pages: Price $3.25. To be published August 15, 1961, by David McKay Company Inc., 119 West 40th Street, New York 18, New York.

PLAY IT BY EAR, a book of Auditory Training Games by Edgar L. Lowell and Marguerete Stoner with the collaboration of Edith M. McIntire, Jean M. McNeil, Patricia M. Smith and the editorial assistance of Joan Hounsfield—John Tracy Clinic, Los Angeles, California, 1960.

This book is based on a body of ideas that grew up around the experiences of the authors in developing good listening habits in young children during the course of a research project sponsored by the Institute of Neurological Diseases and Blindness of the U. S. Public Health Service.

This practical illustrated manual of auditory training games with its comprehensive introduction is designed to help parents and teachers in developing good listening habits in young deaf and hard of hearing children. The major concentration is upon a wide variety of simple games that will be fun for a young child to play and will hold his interest. It is organized around some of the sources of sounds that are common occurrence in the life of every child.

Thirty-six activities are grouped into five main categories: Sounds—Music—Voice—Distance—Direction are described in detail under the headings of Purpose of Activity, Materials Needed, How to Play, Variations to Maintain Interest, to Increase Language Difficulty, to Increase the Difficulty of Auditory Discrimination and to Increase Complexity.

It is suggested that *Play It By Ear* may follow the Correspondence Course of the John Tracy Clinic which is available without charge to all parents of preschool age deaf and hard of hearing children. 187 pages: Price $3.50 postpaid (California residents add 4% sales Tax) Copies may be obtained from John Tracy Clinic, 806 Adams Blvd., Los Angeles 7, California.

NEWS FOR YOU, Robert S. Laubach, publisher; Caroline Backley, Editor. This weekly periodical is published October through May. It is concerned with current high-interest materials and is written on an easy-to-read level. It is a new service, expressly written for persons learning English as a second language. Strict attention is paid to the control of patterns of speech which tend to cause more troubles than vocabulary alone. Articles are written by student and professional writers, under the direction of the publisher and editor. Expert linguistic counsel is employed with every article. The March 8, 1961, issue included the following materials: "All Aboard for World Peace" by Usher Ward; "A Scottish Immigrant Invented the Telephone"; "King of Morocco Dies"; "Large Power Plant Opens" (Robert Moses Niagara Falls Project); "Brazil Elects a New President," and "Extra, Extra," Discussion of "Peace Corps."

It has been suggested that the material in this publication should prove effective in working with adult aphasics. Subscription Rate—$1.00 for 17 weeks with special group subscription rates.

Address: News For You, Box 131, Syracuse 10, New York.

THE ACRONYMS DICTIONARY—a guide to alphabetic designations, for associations, societies, nonprofit organizations, international organizations, government agencies, United Nations agencies, business firms, colleges and universities, aerospace and electronic equipment and terms, transport facilities, military terms, and general terms. The wide use of the Acronym is pointed out by the more than 12,000 listings in the book. An editorial introduction preceding the individual entries traces the origin, historical development and current status of acronym usage. 192 pages cloth bound: price $10.00. Publication may be examined on 30 day approval with no obligation to buy. Available at Gale Research Company, 22nd Floor Book Tower, Detroit 26, Michigan.

THE HANDBOOK OF PRIVATE SCHOOLS, Porter Sargent, 1961. The forty second edition is as complete and up-to-date reliable and objective as the previous editions. The programs of thousands of secondary schools included are accurately evaluated by the staff without favoritism. Maps, full indexes, classified finding lists, and other features assist the reader in locating or choosing a school. Pertinent statistics are conveniently displayed: boarding and tuition charges, plant improvements, scholarship aid, special programs, these and many other facts are included. 1280 pages, cloth bound: $10.00. Publication date June 30, 1961. Available at 11 Beacon Street, Boston 8, Massachusetts.

HANDOOK FOR LIVING; A collection of most everyday expressions, labeled pictures at approximately third grade level.—Price $1.00.

HOMETOWN USA; A collection of business expressions in story form at fourth grade level. $1.00. Books may be ordered from: Betty Lou Points, 2712 Sanborn, Amarillo, Texas.

Readers are urged to contact Vivian I. Roe, Department of Speech, Alabama College, Montevallo, Ala., Associate Editor of CLINICAL AND EDUCATIONAL MATERIALS if they have information of pertinence to this Department.

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News and Announcements

ORGANIZATIONAL

A symposium, Research With The Deaf—Its Implications for General Psychology, will be presented on Saturday, September 2, 1961, at the Hotel Roosevelt, New York during the convention of the American Psychological Association. Division 22, The National Council on Psychological Aspects of Disability is sponsoring the meeting. Hans G. Furth, Catholic University, will serve as Chairman. Participants will include: Solis Kates, University of Massachusetts and Clark School for the Deaf, "Conceptual Capacities in the Deaf"; J. P. Schein, Gallaudet College, "Word Association Conformity in Deaf and Hearing College Students"; Arthur Neyhus, Northwestern University, "The Use of Projective Tests of Personality with the Adult Deaf"; and Rubern A. Mendez, Catholic University, "The Influence of Language Experience and Age on Gestalt Laws of Perception." Heinz Werner of Clark University will serve as discussant.

The XII Congress of the International Association of Logopedics and Phoniatrics will be held in Padua, Italy, August 29-September 4, 1962. The following official reports will be presented: "Modern Research on Experimental Phoniatrics" (J. Van den Berg), "Functional Dysphonia" (J. Perello), and "Diagnostic Procedures in Auditory Disorders of Children" (L. M. DiCarlo). Papers are invited on subjects stated and on subjects of choice relevant to any other aspect of speech and voice. Not more than one unpublished contribution may be submitted by any one member of the Congress. The title of the contribution must be submitted not later than *September 30, 1961.* A brief abstract, not exceeding 200 words, must be submitted by *November 15, 1961.* All communications should be sent to Congress Secretary: Caterina Croatto-Martinolli, Centro Medio-Chirurgico di Foniatria, Via Bergamo, 10-Padova, Italy.

The sixth International Congress of Audiology will be held in Leiden, The Netherlands, September 5-8, 1962. Three roundtables are planned as a part of the program. The subjects of the roundtables are: "Frequency Analysis of the Normal and Pathological Ear," Moderator: G. von Békésy; "Central Deafness in Children," Moderator: J. M. Tato; and "Psychogenic Deafness and Simulation," Moderator: H. A. E. van Dishveck. Although English, French, German, and Spanish will be the official languages of the Congress, English and French will be the working languages. Information about the Congress is available from the Secretariat: A. Spoor, Ear-Nose-Throat Department, Academisch Ziekenhuis, Leiden, The Netherlands.

The International Society for the Rehabilitation of the Disabled, in cooperation with the Reader's Digest Foundation, has established the Reader's Digest International Rehabilitation Awards. The Awards will be presented to those organizations which have done the most to advance and improve rehabilitation services and facilities for the handicapped within their communities during the two-year period, January 1, 1961 to December 31, 1962. Seven awards ranging from $500 to $2500 will be presented at the 9th World Congress of the International Society, Copenhagen, June, 1963. Any organization concerned with rehabilitation in whatever degree, in any country of the world, is eligible to apply. A specially prepared brochure outlining the procedures for application is available on request from: The International Society for Rehabilitation of the Disabled, 701 First Avenue, New York 17, New York.

Helping Parents of Handicapped Children: Group Approaches, recently published by the Children's Hospital Medical Center, Boston, and the Child Study Association of America, contains the proceedings of a 1959 Conference which was jointly sponsored by these two organizations. The publication is of interest to professionals and parent educators planning or conducting group programs for parents of handicapped children. The needs of the handicapped child, the psychiatric implications underlying parents' concern for these children, what parents gain from different kinds of group experiences, and community planning for parents of handicapped children—these are some of the subjects dealt with in this book by prominent authorities from the fields of medicine, public health, psychiatry, and parent education. Individual copies of the book are available at $1.25 from the Child Study Association of America, 9 East 89th Street, New York 28, New York. Quantity rates may be obtained on request.

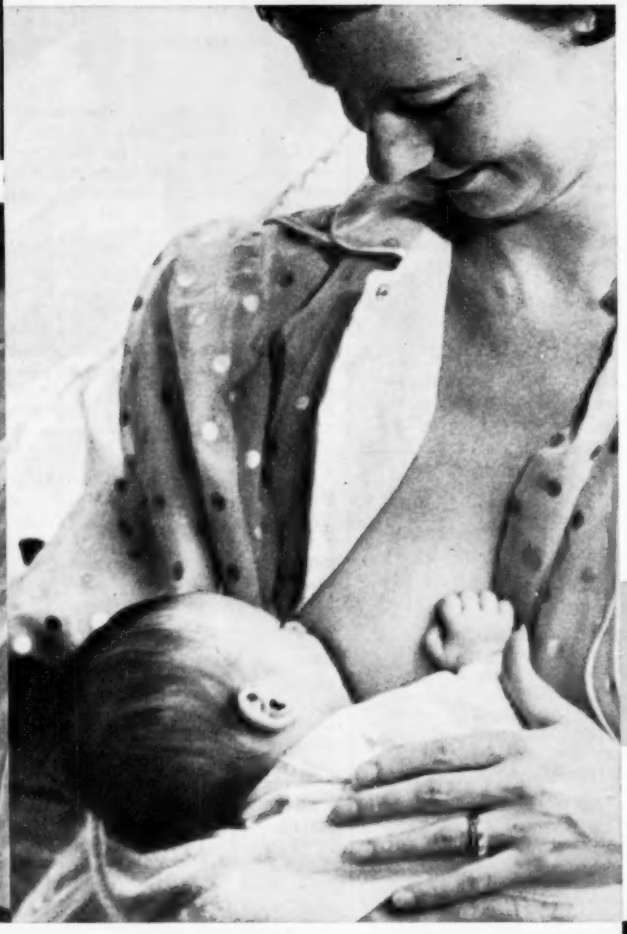
Proceedings of the 8th World Congress of the International Society for Rehabilitation of the Disabled are now available. The *Proceedings,* which were edited by Eugene J. Taylor, include reports on all general sessions as well as selected papers and lectures presented at the Congress. Copies are available from ISRD, 701 First Avenue, New York 17, New York at $1.00 each.

The Center for Applied Linguistics, which was established by the Modern Language Association of America in 1959, acts as a clearing house and informal coordination body in the application of linguistic science to language problems. It is a nonprofit, professional organization. The Center publishes the *Linguistic Reporter* as a bi-monthly newsletter to exchange information in the field. The Center is compiling a Roster of Linguists, which will include specialists in foreign language teaching, linguistics, the teaching of English as a foreign language, and speech. Eligible personnel are encouraged to obtain questionnaire forms from the Center. Another project is the compilation of a list of Master's and Ph.D. theses in the field of applied linguistics. Titles of such papers should be sent to Miss Sirarpi Ohannessian, at the Center, 1346 Connecticut Avenue N.W., Washington 6, D. C.

The Comparative Education Society and the Commission on International Education of Phi Delta Kappa are sponsoring jointly a seminar and field study, Reforms and Policy Making in European Education, November 11-18, 1961. The itinerary proposed for the seminar includes London, Paris, Hamburg, Stockholm, and Moscow. Participation is open to anyone interested in the seminar topic. Further information and application forms are available from Gerald Read, Secretary-Treasurer, Comparative Education Society, Kent State University, Kent, Ohio.

During the 61st meeting of the Acoustical Society of America, the Society's Gold Medal was awarded to Georg von Békésy. Békésy received his Ph.D. in physics from the University of Budapest in 1933, and was a member of its faculty until 1946. Since 1948 Békésy has been senior research fellow in psychophysics at the Harvard University Psycho-Acoustic Laboratory. The citation, which accompanied the award, stated, "He has witnessed the microscopic movements of the cochlea, measured the mechanical properties of its parts, and deciphered the electrical geometry of its transducing structures. Master of manipulators, maker of models, analyzer of motions, he has fathomed the enigmas and disclosed the elegance of the auditory system."

THE NUK SAUGER PROGRAM, a promising development for prevention and early care



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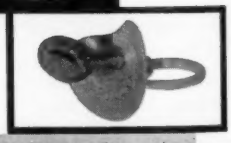
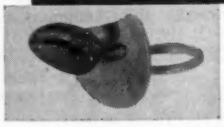
At first it seemed that only orthodontists were interested. Now others, particularly many in your Speech and Hearing Association, are also intrigued with its possibilities. You can be sure we will be glad to send you the descriptive booklet and will welcome any comments you might have.

CONVENTIONAL NIPPLE

NUK SAUGER NIPPLE





THE NUK SAUGER PREVENTIVE ORTHODONTIC PROGRAM

The Nuk Sauger Program is a European Development, which Rocky Mountain has been market-researching for over two years to determine: (1) whether or not the American Professions and parents would accept and use such a program, (2) possible changes to fit American requirements.

THE ELEMENTS OF THE PROGRAM ARE:

(1) NUK SAUGER NIPPLE A more natural nursing method to encourage healthier development of jaws and oral structures. It also helps prevent reverse swallowing and harmful mouth habits associated with overdeveloped sucking and drinking reflexes, which often result from bottle nursing with round, drinking type nipples.

(2) NUK SAUGER PRIMARY EXERCISER A worthwhile substitute for the thumb, designed to offset possible harmful effects of thumb sucking and to promote normal oral development.

(3) NUK SAUGER SECONDARY EXERCISER For treatment of oral malformations caused by improper nursing nipples, mouth habits, mouth breathing, thumb sucking, etc.

SAMPLES AND LITERATURE—While samples must, of necessity, be limited, we will be glad to send you reprints of articles from the American Journal of Orthodontics related to this subject and our latest booklet, "*The R.M. Nuk Sauger Program.*"

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The Easter Seal Research Foundation has continued for the third year a grant to Maury Massler, professor and head of the Department of Pedodontics, University of Illinois College of Dentistry. Massler is studying the enamel and growth rings in children's teeth to attempt to determine the exact time when the agent or agents responsible for certain handicapping conditions occurred in prenatal development. According to Massler, the teeth of children contain growth rings that reflect the developmental history of the child. Massler also states that fevers, malnutrition, and diseases of the mother can be identified when the teeth are analyzed microscopically. Massler has found that prebirth enamel disturbances in athetoid children, while not yet isolated as to cause, occur about the fifth month of pregnancy and can be determined within one week of occurrence.

The May 1961 *Bulletin* (No. 49) of the Legal and Legislative Department of the United Cerebral Palsy Association, Inc., includes several items of particular interest. In response to numerous requests, information concerning life and endowment insurance policies for children and adults with cerebral palsy is included. The *Bulletin* also calls attention to several recent rulings about tax deductions for certain special educational, medical, and charitable expenses. For example, a new ruling by the U.S. District Court of Texas (Donovan vs. Campbell, Dallas Division Ci 8273) held that a father should be allowed a tax deduction for tuition fees to a special school for the deaf in which he enrolled his son on the advice of a physician. A review of state laws passed in 1961 that were related to any aspect of rehabilitation of the handicapped is also featured.

The Community Council of Greater New York has published a report, *Salaries and Related Personnel Practices in Voluntary Social and Health Agencies in New York City: September, 1960.* According to the findings of this survey, recent salary increases have exceeded the rise in the cost of living, but do not as yet meet recommended professional standards or comparable industry levels. The clerical salaries in voluntary agencies are well below those of industry and the longer vacation provided does not compensate for the salary differential. The work week does not differ significantly, but very few of the voluntary agencies match recommended retirement plan standards. Data for the study was obtained from 162 agencies. Copies of the report at $1.50 each may be obtained from Publications Department, Community Council of Greater New York, 345 East 45th Street, New York 17, New York.

INSTITUTIONAL

The Lancaster Cleft Palate Clinic will present a course October 9-12, 1961, concerned with the habilitation/rehabilitation program of the oral-facial-speech handicapped. Graduate traineeship awards through the National Institutes of Dental Research, Department of Health, Education, and Welfare, are available to qualified individuals in the fields of medicine, dentistry, speech, and special education. Inquiries concerning the program should be sent to: Robert T. Millard, Program Director, Lancaster Cleft Clinic, 24 North Lime Street, Lancaster, Pennsylvania.

The American Academy of Arts and Sciences is receiving applications for grants-in-aid for research in any recognized scientific field. The grants, which range from $500 to $1500 per grant, are usually awarded to individual scientists rather than institutions and projects dealing with explorations of the frontiers of knowledge are preferred. Support is usually not given for research aimed primarily at meeting degree requirements. Applications should be submitted before September 1, 1961 to the American Academy of Arts and Sciences,

Committee on Research Funds, 280 Newton Street, Brookline Station 46, Boston, Massachusetts.

The inauguration of a post-doctoral program in Medical Audiology has been announced by Northwestern University. This program is supported by a grant from the National Institute of Neurological Diseases and Blindness and is conducted jointly by the Department of Communicative Disorders, School of speech, and the Department of Otolaryngology, School of Medicine. Under the provisions of the grant, two traineeships are awarded annually. Each trainee may pursue an individualized curriculum of study for from 1 to 3 years, depending on his prior experience and goals. Further details are available from Raymond Carhart, Hearing Clinic, Speech Annex Building, Northwestern University, Evanston, Illinois.

The University of Buffalo has expanded its graduate program in speech pathology and audiology. Two new faculty positions have been created and will be filled by D. Kenneth Wilson and Donald J. Sharf, effective September, 1961. Bryng Bryngelson and Gladys Reid Jann are serving as visiting professors in the summer session at the University of Buffalo.

Representative George M. Rhodes of Pennsylvania introduced a bill into the U.S. House of Representatives on February 17, 1961 which would grant a deduction for income tax purposes to handicapped individuals for the expenses for transportation to and from work. The bill would provide an additional exemption for income tax purposes for a taxpayer supporting dependents who are so handicapped as to be unable to care for themselves. The bill was referred to the Committee on Ways and Means.

Patricia Winalski of Glastonbury, Connecticut, has been appointed Consultant for Special Services for the Deaf, and will head a new division in the U.S. Department of Health, Education, and Welfare. This division will coordinate and centralize all federal activities for the deaf. Winalski is a member of the Board of Directors of the American School for the Deaf, Hartford, Connecticut, from which her son was graduated in June, 1961.

A group from the Institute of Physical Medicine and Rehabilitation, New York University Medical Center, has recently completed a 30-minute tape on "Advising Young People on the Career Opportunities of Going Into Rehabilitation Services," for the Opinion Institute, P. O. Box 1408, Omaha, Nebraska. The tape will be distributed by Opinion Institute as one of a series to be used in guidance classes on the senior high school and college freshman levels.

The Lexington Deaf Oral School, Lexington, Kentucky, was organized in September, 1960 by parents of hearing impaired children, and with the Optimist club of South Lexington as sponsor. The purpose of the school is to teach speech and lip reading to preschool deaf children. A Board of Directors assisted by an Advisory Board of professional people will govern the school which will open in September, 1961. Norma Harris of the University of Kansas Medical Center has been selected as the first teacher-director of the school.

"Hearing Problems in Adults," a short course for vocational rehabilitation counselors, was presented by the Speech and Hearing Center, Tulane University School of Medicine on March 22-23-24, 1961. The faculty included: Leroy Hedgecock, Consultant in Audiology to the Mayo Clinic, members of Tulane Department of Otolaryngology, and personnel associated with the state divisions of vocational rehabilitation of Louisiana, Arkansas, and Oklahoma. More than forty counselors attended the course, many of them under traineeships provided through a grant from the U.S. Department of Health, Education and Welfare to the Tulane Division of Graduate Medicine.

A conference sponsored by the Elementary Schools Section Staff in the U.S. Office of Education was held in October, 1960 to prepare a composite statement on Elementary Schools. The educators and leaders were invited to "analyze, interpret, organize, and condense" the 235 recommendations on elementary education made by the 1960 White House Conference on Children and Youth. The result was a description of the elementary school that lives up to the ideal delineated by the 1960 White House Conference. A summary of the conclusions of the Office of Education Conference is presented in an article in *School Life*, January, 1961. Some of the attributes of this ideal school are of particular interest. "*This elementary school knows its role*—a primary role to make available to all children experiences which will stimulate each student to develop his potential to the fullest and to meet his intellectual, moral, spiritual, aesthetic, vocational, physical, and social needs as an individual, on American citizen, and a member of the world community. *This elementary school tries to educate all children.* It welcomes the gifted and the handicapped as enthusiastically as it welcomes all those called normal, and provides with equal energy for children with unusual needs and children with unusual talents. It is dead set against denying educational services to any child and opposes the lowering of compulsory education laws. *This elementary school provides special educational services* . . . the school provides organized services for those with special needs. It provides guidance for underachievers; . . . therapy for children with speech problems; supporting services for migrant children; and any other services that will improve the educative process. *This elementary school has a highly professional staff.* . . . Its teachers are well-educated. . . . They understand children. . . . Their academic background is so broad and diverse that they are able to draw on all disciplines to build the curriculum. Every teacher has been specially prepared for the kind of teaching he does. . . . The school manages to attract such teachers not only by paying salaries commensurate with the high requirements, but by providing an attractive professional environment."

Although the conference recognized that the school it described is a composite ideal, it also believed that such schools do exist in some enlightened communities.

The Mexican Institute of Audition and Language is celebrating its 10th Anniversary between August 5 through August 13th in Mexico City. They will sponsor an art show of drawings, sketches and paintings done by the deaf pupils of the schools for the deaf of America. ASHA members are urged to submit examples of work done by their pupils to Miss A. MarVinez Negrete, Instituto Mexicano de la Audicion 6 el Lenguaje, Av. Progreso No. 141-A., Mexico City, Mexico.

PERSONALS

Hilda F. Amidon has become a Life Member of ASHA. She received her B.S. degree from New York University in 1935 and an M.A. from State University of Iowa in 1941. Since 1949 she has been the Coordinator of Speech and Hearing Services for the public schools of Hartford, Connecticut.

C. Cordelia Brong, Louisiana State University, was elected First Vice-President (President-elect) of the Southern Speech Association at its Annual Convention in Miami, Florida, April 3-7. Brong has served as a member of the S.S.A. Committee on Speech and Hearing Disorders for the past three years and was Chairman during 1960.

James Jerger, Northwestern University, has accepted a new assignment effective September 1, 1961. Jerger will fill a position as Director of the Auditory Research Laboratory, Veterans Benefits Office, Washington, D.C. Jerger will also be employed part-time as Research Professor of Audiology, Hearing and Speech Center, Gallaudet College.

Kenneth O. Johnson was honored as a distinguished alumnus by Macalester College, St. Paul, Minnesota. The "Useful Citizen Award" was presented during the commencement ceremonies at the College in June.

Norman J. Lambries, Executive Director of United Speech and Hearing Services, Greenville, South Carolina, has been named recipient of the William R. Duffey Memorial Award at Marquette University. This annual award is made to an outstanding alumnus of the Marquette School of Speech for his work in the field of speech pathology.

S. Richard Silverman, Central Institute for the Deaf, was granted an honorary Doctor of Letters degree by Gallaudet College at its 79th Commencement on May 29, 1961.

Svend Smith, of Copenhagen, Denmark, and Secretary-General of the International Association of Logopedics and Phoniatrics, spent ten weeks this summer at the National Institute of Dental Research, Bethesda, Maryland. Smith, a well-known phonetician, was associated with **James F. Bosma.** Bosma is Chief of the new Oral and Pharyngeal Development and Function Section at N.I.D.R.

Alfred J. Sokolnicki, Marquette University, was awarded an honorary Doctor of Humane Letters degree by Alliance College, Cambridge Springs, Pennsylvania at its commencement on May 28, 1961.

C. Raymond Van Dusen, Chairman of the Department of Speech, University of Miami, has resigned to become coordinator of basic studies at Brevard Junior College, Cocoa, Florida.

Several new appointments have been announced by the Veterans Administration: **Albert W. Knox** will become Chief, Audiology and Speech Pathology Services, V.A. Hospital, Kansas City, Missouri. **Otto J. Menzel** will become Chief, Audiology and Speech Pathology Services; **Walter W. Amster;** Speech Pathologist, and **G. Donald Davidson,** Audiologist, at the V.A. Hospital, Coral Gables, Florida. **Gerald Studebaker** will assume the position of Chief, Audiology and Speech Pathology Services, V.A. Regional Office, Syracuse, New York. **James L. Aten** joins the staff at V.A. Hospital, Seattle, Washington as Speech Pathologist. **James F. Kavanaugh** has become Speech Pathologist in the Veterans Benefits Office, Washington, D.C.

NECROLOGY

Cloyd S. Harkins was born in Orafino, Nebraska, November 16, 1888 and died while attending a professional meeting in Philadelphia, Pennsylvania, March 22, 1961.

Harkins received the D.D.S. degree from the University of Pennsylvania in 1910 and he practiced dentistry in Osceola Mills, Pa., from that date until his death. In 1935, Harkins became a Fellow of the American Academy of Dentistry and in 1954 he became a Fellow of the International College of Dentistry. He was also a Fellow of the American Speech and Hearing Association.

Forum

LET'S STAY WHERE WE ARE

Anent the recent proposal to up the requirements for certification in ASHA I wish to utter a word of protest.

Many of you know that I have often complained about the slowness of change. My nervous system demands fast action. Protesting the proposed change in our organization is not prompted by my increasing age due to popping of arteries, but to the projection of a little more wisdom into important matters.

Some day we will no doubt be ready for a split in our profession. Speech pathologists who function in universities, hospitals and rehabilitation centers can some day well afford to set themselves up as a separate entity. Public school clinicians, now the major portion of our membership, have a different, but equally important function to perform in dealing with handicapped children.

The latter group needs the hierarchy of research and Ph.D. erudition of the speech pathologists for guidance a few more years. We sprang from General Speech, but not after many years of dependence.

Just because the land has been overrun by water nine times already is no reason to fear the tenth being close at hand. It will take 5,000 years for Cape Cod to be under water. We, talking primates, tend to consider that this world is in its last chapter, and therefore we hasten to save it. In the process we drain the blood out of the veins of our cherished youth every quarter of a century.

The estimate of the world's age is now upwards five billion. It may, even, never had had a beginning—so why all the hurry. This age might well be thought of as the first chapter in all life's existence, and let's consider more carefully, drastic changes we may dream about.

I feel certain were our certification requirements changed at this time, the four year college programs would fold up. They couldn't all afford a five year program.

Our present administration should concentrate on getting a more economical and sensible public school program. This involves eliminating in the undergraduate programs all courses in the college of education, now required by speech clinicians, that are required of the general classroom teacher. Undergraduates need this time for courses in the sciences which would better prepare them for clinical work. The problem of case load for the public school clinician is another area the association should have concern over. Reduce it from 100-300 per clinician to 25-50 as a maximum. Encouraging results and a saving of money would eventuate.

Last but not least, work toward the end of having all the currently practicing speech clinicians meet our present requirements for membership. By approving the proposed changes, we are literally thumbing our noses at them, saying "You are no good and you will never make it." Shame on us.

Bryng Bryngelson
University of Minnesota
Minneapolis, Minn.

The American Speech and Hearing Association is a multi-level organization. From this stems much of its uniqueness and its strength. At our Conventions the public school therapist may learn first-hand from leaders in her profession, who in turn benefit from the constant stimulus of the expressed need for wider knowledge and newer therapeutic approaches.

Recent events have pointed toward a substantial change in this characteristic of ASHA. The Executive Council, in the March, 1961, issue of *Asha*, has proposed abolition of the B.A. level of membership starting in 1963, and establishment of a single level of certification. The membership will be asked to approve these changes in November. I have no quarrel with the certification change, which provides an incentive toward a higher standard of clinical competence without threatening our growth. The membership change is a vastly different step. I share with Van Riper his feeling that the step is premature and may well prove disastrous.

In a separate article submitted to this Journal, I have reported rather striking differences in professional self-image among different levels of ASHA members. Typically, the ASHA Fellow or the Non Fellow Ph.D. chooses to call himself either a Speech Pathologist or an Audiologist. Contrastingly, the Bachelor's and Master's group prefer to regard themselves as Speech Therapists. Data on major professional activities of these groups indicate that as an individual ascends higher in the spectrum of our profession, he begins to lose the role of a therapist and takes on increasingly that of an administrator, professor, or research scientist.

I view the function of therapy and the rendering of direct clinical help to the speech or hearing handicapped person as the backbone of our profession. If therapy is the task of the "lower" levels of our membership, as it evidently is, I seriously doubt that even the cause of the "Chiefs" will be served by killing off the "Indians."

These "Indians," at least, have a word for it—their word is "Speech Therapist." This title, the overwhelmingly preferred self-designation of the public school therapist, has been virtually banned in the official ASHA publications. Following the attempted elimination of the title (a rather abortive attempt, for it keeps springing back up anyway), the five-year membership proposal would eliminate for the future most of those who now carry it.

A clear implication of the contrast in self-designation at Doctoral and nondoctoral levels of membership is that the professional image that the current guiding forces in ASHA are trying to create is seriously at variance with the self-image of the bulk of the membership. Further evidence for this is the substantial opposition to the proposed membership change that cropped up in the recent regional meeting discussing this issue.

My plea is this: Can't we keep our multi-level organization? Must we drive out the speech therapists—first in name and then in person? What will be the justification, the *raison d'etre*, of our organization once the therapists have departed the scene? The present proposed abolition of the B.A. level member does not of course, effect this immediately, but is it not a long step in that direction? If this movement continues, the therapists will leave our organization and form or join another. And what would our field be like minus the therapists? Without input from and application to therapy, much of our research effort will approach close to utter sterility. Worse, it may become a droll academic schizophrenia, speaking in a neologistic special language, seldom ever touching the day-to-day reality of the handicapped person.

Let's preserve the multi-level character of our professional group. Unless we do, we may eventually find ourselves in a field of speech therapy without speech therapists.

Joseph G. Sheehan
University of California
Los Angeles, Calif.

ANOTHER QUESTION TO BE ANSWERED

The lucid and informative article by K. O. Johnson and Parley W. Newman in the April, 1961, issue of *Asha* regarding trends in our profession calls attention to both strength and weakness in the rapid emergence of speech correction

and audiology as recognized services. In spite of the fact that much in the report is gratifying, there are some danger signals revealed which should serve as warnings to persons concerned with the preparation of professional workers.

We do think, however, that certain interpretations might be questioned. In the discussion of certification it is noted that in 1955 as well as in 1960 approximately 12% of the membership held advanced certification. This implies that there has not been an increase, proportionately speaking, in the number of people having advanced training. We question this because unfortunately, certification and even membership in ASHA does not give a correct picture of the qualifications of all the workers. As an example of this, in the school year of '59-'60 Illinois (outside Chicago) had 113 public school correctionists who had Master's Degrees. Of this number, 90 had post-master's work. It is true that in a few instances, possibly one-fifth or less, the advanced work had been in related fields. A check of the 1960 American Speech and Hearing Directory revealed the following concerning the membership of the 113 people:

No. Persons	Certification
19	Basic
4	Advanced
38	Not classified

And, most startling, 52 were not members.

In all likelihood, the great majority of the 113 people could get advanced certification if they applied for it.

While we are unable to check the ASHA membership in other years, an Illinois survey in '53-'54 indicated that 15% of the total number, or 46 correctionists, had Master's Degrees only, and 5%, or 15 correctionists had work beyond the Master's level. Now the order is reversed and 5% have only the Master's level while 15% have post-master's work. These studies show that in Illinois there is a very noticeable trend toward advanced training. The same may well be true in other states even though it is not evidenced in ASHA membership.

The question of why many well qualified correctionists do not feel the need for being members of ASHA is pertinent. It may be that resolving this question would provide greater opportunities for professional growth and solidarity than will the results of the current efforts to relegate undergraduate programs to inferior status.

Martha E. Black
Office of Public Instruction
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LET'S MOVE FORWARD

I have read the letter of my dear friend C. Van Riper, entitled **ASHA Standards.** I certainly am in sympathy with the motivation of his letter. He and I have, over the years, defended the interests of the speech clinician and the teacher of speech correction. Against vigorous opposition we urged the creation of a second Journal, so that clinicians and teachers would have a publication of their own, and so that they would not be oppressed by esoteric articles on research. In my Cincinnati speech, **Ibi Fuistis,** I made an heroic figure of the speech clinician and teacher, over and above the administrator, the researcher and the writer. I have reason to believe that my friend Van Riper endorsed that stand. So I agree with Van's motives. I do, however, disagree with his suggestions as to the way to encourage this large and important group.

It seems to me that the principle of elevation of the standards of certification is a sound one; and it does no injustice to any member, since the members who now hold the Basic Certificate will be automatically raised in standing to a status comparable to what is now advanced standing. The provisions for our present speech clinicians and speech correctionists are certainly not unfair. They are generous and will tend to encourage these people to stay in ASHA, where they get real recognition and prestige.

Van makes a point of the fifth year required for certification. We must face the fact that the A.B. Degree means about what the High School diploma meant a generation ago. It is just not possible to crowd into the A.B. program enough technical courses to prepare for what we can call a real profession. The liberal arts degree is an absolutely necessary foundation for a profession that deals with the lives of human beings; so our members in training must extend their programs to the end of the fifth year at least.

This requirement may temporarily hurt a few people, and also a few colleges; but the ASHA stand on these matters will persuade both students and colleges to make adjustments that will in the end redound to the greater good of the patients and pupils whom we serve.

Robert West, Director
Speech and Hearing Center
Brooklyn College, Brooklyn, New York

I write to disagree with the opinion expressed by C. Van Riper in the July issue of *Asha* (Forum, P. 232). More specifically, I take issue with the basic premise about which most of his letter seems to revolve, if not "spin." Reference here is made to his statement ". . . the certainty, that it (a change in membership requirements) will drastically split off the major segment of our profession—those who work in the public schools."

How can such "certainty" possibly exist? We will not know the final wording of the proposed change in membership requirements until it is submitted for a vote. It follows that we do not know the outcome of this vote. Finally, assuming the membership cast a favorable ballot for the change, a four to five year period would probably be required to realistically assess the effect of the new requirement.

I challenge Van Riper to support his contention with evidence. What accumulation of fact leads a clinician to make such a "diagnosis"? For that matter, to what degree would a professor condone such unsupported assumptions by his students? The content and rhetorical nature of Van Riper's letter reminds me of the man who wished to borrow a jack handle. A salesman travelling a lonely road late at night had a flat tire. In due time, he discovered his jack handle was missing. He remembered seeing a farm house about a mile earlier and decided to borrow this tool from the farmer. While walking that mile, he thought only of the many reasons the farmer might have for not making the loan. By the time he reached the farm house, he had convinced himself the farmer was going to be aggravated and wouldn't loan him the jack handle. But, he knocked and awakened the farmer. Then, before the farmer spoke a word the salesman said, "All right, so keep your d—— jack handle." How does Van Riper know what action will be taken by us in the public schools? His speculation, at this time, is grossly in error with respect to many in Iowa. He would also appear in error with respect to at least a few in Kansas (James McLean's letter, May 1951 issue of *Asha*, Forum P. 175).

I regret that Van Riper feels he has a right to put words in my mouth. My past admiration and respect for him will not permit me to question his motivations. I can only assume he has a sincere belief that children's needs will be best served if ASHA membership requirements are not, in the near future, revised upward. Such sincerity, however, does not justify his prophecy that I, as a public school clinician, will "split off" as a result of a change in membership requirements when, as a matter of fact, I favor a revision. If there is potential danger of a division in our profession, I have no evidence to indicate it emanates from public school clinicians. Rather, Van Riper's letter to the editor and his reported circulation of similar correspondence to friends and students would seem to indicate who must bear at least partial responsibility for jeopardizing the integrity of our profession.

My bias, as previously implied, happens to be that a change in membership requirements will benefit those we serve and thus ourselves. Several considerations led to this opinion and the reader has a right to know these. My listing will be limited to those I feel most important and they will not be presented necessarily in the rank or order of importance.

1. **Higher standards seem inevitable.** They appear to be one reflection of growth in most societies. Contrary to Van Riper, I feel we have grown beards, or at least the "stubble," of wisdom, though we still wear kneepants in terms of our standards for training programs. Due to the substantial accomplishments of the public school clinicians and others in service settings, the researchers and the professors, we now seem ready for a change. We are capable of doing better. Let our standards attest to this fact.

2. **Higher standards of training lead to an increased supply of personnel.** (National Education Association, *The Postwar Struggle to Provide Competent Teachers,* "The High Standards Approach," Research Bulletin, October, 1957, P. 120-123).

3. **There is a general trend in the nation's public school framework toward raising certification requirements for all school personnel.** Unless ASHA exercises its responsibility for providing leadership to those who issue these certificates to clinicians, a day may soon arrive when state education agencies will overlook their guidance. Many, if not most, states presently "exceed" ASHA requirements in that they require professional courses in education in addition to specialized preparation in speech and hearing (Irwin, R. B., *Speech Therapy in the Public Schools: State Legislation and Certification* JSHD, 24, 1959, P. 127-143).

Furthermore, some states reportedly have or are considering the M.A. level of preparation for school personnel. The question seems to be not so much whether standards should be raised as who should provide the leadership in this effort as it relates to speech and hearing services.

4. **Most public school clinicians with a B.A. Degree, in my experience, have expressed, during their first year on-the-job a desire for a more comprehensive background of training.** Specifically, they have reported inadequate preparation for dealing with problems of program management, of "screening" large populations, and of children with impaired speech associated with organic conditions. Some training program heads have informed me of similar experiences. There are two references which may be cited as generally supportive of these personal experiences. (Mackie, Romaine P. and Johnson, Wendell, *Speech Correctionists: The Competencies They Need for the Work They Do,* U. S. Office of Education, Department of Health, Education, and Welfare, Bulletin 1957, No. 19 and Johnson, Kenneth O., and Newman, Parley W., "Trends in the Profession," (*Asha,* April 1961, P. 111.)

5. **A change in membership requirements would apply only to those who become members following establishment of new standards.** Furthermore, I here pledge every effort to protect the employment opportunities for those who presently hold B.A. Degrees should a change which proposes more extensive preparation receive a favorable vote from the membership. There is no doubt in my mind that other state directors of speech services would exert similar effort.

I submit that if anyone is "running scared" it is Van Riper. He writes the language of panic. In his second paragraph, he admits to a feeling of desperation. As a youthful profession, we have the necessary energy, vitality, and desire to grow. As individual members of this profession, we are capable of speaking our own minds. Those who believe otherwise insult us.

Dale Bingham
Consultant Speech Therapy Services
Iowa State Department of Public Instruction
Des Moines, Iowa

The matters discussed by Van Riper in his letter to the Editor of *Asha* (July 1961) appear to me to deserve the thoughtful reflection of every one of us.

I believe the basic question to be this: How can we as a profession most effectively meet our responsibilities for providing clinical speech and hearing services?

This question is to be answered, I believe, with an eye to the needs of (a) the handicapped persons whom we serve, (b) the executives and administrators who are responsible for the institutions and agencies in which we are employed, (c) our fellow workers in the educational, medical and other professions with whom we cooperate, (d) the young men and women who want to prepare themselves to work in our field, and (e) the working members of our profession.

All of these persons would seem to require a particularly clear answer to this question: How is a member of our profession to be recognized as clinically competent?

Since 1943 ASHA has officially answered this question in terms of its standards of clinical certification. With basic and advanced levels of certification, however, our clients, employers, our friends in related professions, our prospective students, and our own working members had difficulty in making clear and useful distinctions between these two levels. The basic problem was that only those with advanced certification were officially recognized as qualified to work independently; those with basic certification were officially required to have supervision that was commonly difficult to provide and often nonexistent. After many years of experience, the ASHA membership voted to solve this problem by adopting a single level of certification, one which is intended to mean that the person certified has been judged to be qualified to perform clinical services without having to be provided with supervision.

In so defining "clinical competence" with an eye to the practical purposes of those who use our clinical services, we found ourselves favoring a definition that approximated the level of qualification represented by the old advanced certification, which is generally representative of a Master's Degree level of professional education. A corresponding standard of qualification for membership in ASHA is now under consideration.

The good faith of those of us who were granted either basic or advanced certification under the old requirements has been honored through the generally accepted method of the Grandfather Provision. Just so, it is in keeping with established custom that there be no loss of privilege for anyone who in good faith will have joined ASHA before the effective date of such new membership requirements, if any, as may be adopted by vote of the members.

There are, I believe, two major purposes of the proposal to bring ASHA membership standards into line with the action we have taken in clarifying our certification of clinical competence. One is that of removing a source of public confusion: Now that we have officially said that a clinically competent person in our field is one who has, among other qualifications, the equivalent of a Master's Degree level of professional education, the question arises as to whether we can reasonably expect the public to understand what we mean if we continue to say also that a person may be officially recognized by ASHA as a fully responsible member of the profession with definitely less education than that. The other purpose of the proposed adjustment of membership standards is, I believe, that of positively informing clients, prospective employers, and prospective students that one of the official marks of a member of our profession is an academic degree which represents a certain amount of formal education in the field, whether the member engages in clinical or nonclinical work in speech and hearing. While it is clear that clients and employers need this kind of information about us, just as they need it about physicians, nurses or lawyers, it is also to be considered especially that the same sort of relatively un-

ambiguous information is desirable for young persons who are attempting to plan their programs of professional education.

In this connection, however, the question arises as to why we need to specify the Master's Degree, as such, as a membership requirement, rather than an amount of relevant education generally equivalent to it. We all know persons in our field who do not have the Master's Degree who are good clinical workers. It is commonly accepted that there are medical students without M.D. Degrees who do excellent work on the hospital wards. There are persons without law degrees who are greatly worth consulting about certain legal problems. Yet, as a society we insist that physicians have the M.D. Degree, that lawyers hold the LL.B. Degree, etc. In our field we are subject to the same social custom, but there is no academic degree of Doctor, or Master, or Bachelor of Speech Pathology and Audiology, *per se,* comparable to the degrees of Doctor *of Medicine* and Bachelor *of Laws.* We are left, therefore, with the alternative of selecting the one academic degree available to us that most closely approximates our agreed upon minimum amount or level of professional education. That seems to be the degree of Master of Arts or of Science or of Education.

Van Riper's concern for the members of our profession who work in public school speech and hearing programs is one that I share, and I assume it is shared by all of us. Speech and hearing problems, the persons who are handicapped by them, the professional workers who deal with them, and the services they provide are of the same order of importance regardless of their location, whether in the schools or in hospitals or elsewhere. Everyone who shares this view is necessarily concerned over the heavy case loads in school programs and the related problem of insufficient time for making diagnostic case studies, counseling parents, giving adequate attention to the more seriously affected children, conferring with physicians and other professional workers about specific problems, consulting with teachers, maintaining equipment, preparing materials, programming instruction, keeping records, writing reports, participating in research, attending and contributing to professional meetings, engaging in community relations activities, planning and supervising or cooperating in speech improvement programs, keeping up with current books and journal literature, trying out new equipment and procedures, and doing the many other things that make up a substantially effective and rewarding pattern of professional work. One constructive approach to these problems is that of encouraging students who are planning to work in the schools to undergo sufficient training to prepare themselves well to deal with the problems they are to meet. In view of the magnitude and importance of these problems, the Master's Degree level of professional education seems to me to be desirable and reasonable.

Wendell Johnson
Professor of Speech Pathology
and Psychology
University of Iowa, Iowa City, Iowa

In recent months we have been doing some personal evaluating of our program, and I find I am very much in agreement with the ASHA single level of certification at the M.A. level. Somehow, many programs seem to have overlooked a major function of the B.A. level—to give the student a broad knowledge of his cultural heritage and to develop his competence in and respect for disciplined honest thinking.

Sister Mary Paul Francis
College of the Holy Names
Oakland, California

Van Riper warns us not to adopt as an ASHA membership requirement the holding of a Master's Degree. He calls such action "a hasty step," "a dangerous change," even suicidal, for "it will drastically split off the major segment of our profession —those who work in the public schools."

But professional workers in the public schools are capable of speaking for themselves and they have spoken. Their testimony is reported in Monograph Supplement Number 8 of the *Journal of Speech and Hearing Disorders,* a comprehensive report of a two-year self-study of "Public School Speech and Hearing Services." On pages 129-130 of the summary chapter (Chapter XI) appears this statement:

> Probably the most significant findings of Group VI were in the area of training, where a noteworthy consistent thread could be discerned: the expression of need for more training and training in a limited number of specific subjects. More than 90% of respondents assert that graduate training is at least desirable, if not essential, and a majority favor a five-year requirement for a speech and hearing certificate.

Documentation is provided on page 99 of Chapter VIII, "Professional Standards and Training":

> Over 75% of 705 public school speech and hearing clinicians responding have training in excess of the Bachelor's Degree with 40% of the total number having a Master's Degree or more. Graduate training is considered essential by 47% of 141 supervisors and desirable by 52%, while 42% of clinicians consider it essential and 56% consider it desirable.
>
> In a similar vein, 61% of program supervisors favor a five-year minimum training requirement for a speech and hearing certificate. A majority of clinicians (55%) agree with them.

So, when asked to weigh the matter and speak their mind, the majority of public school workers substitute the words "desirable" or "essential" for the words "hasty" and "dangerous."

Frederic L. Darley
University of Iowa
Iowa City, Iowa

REGIONAL MEETINGS

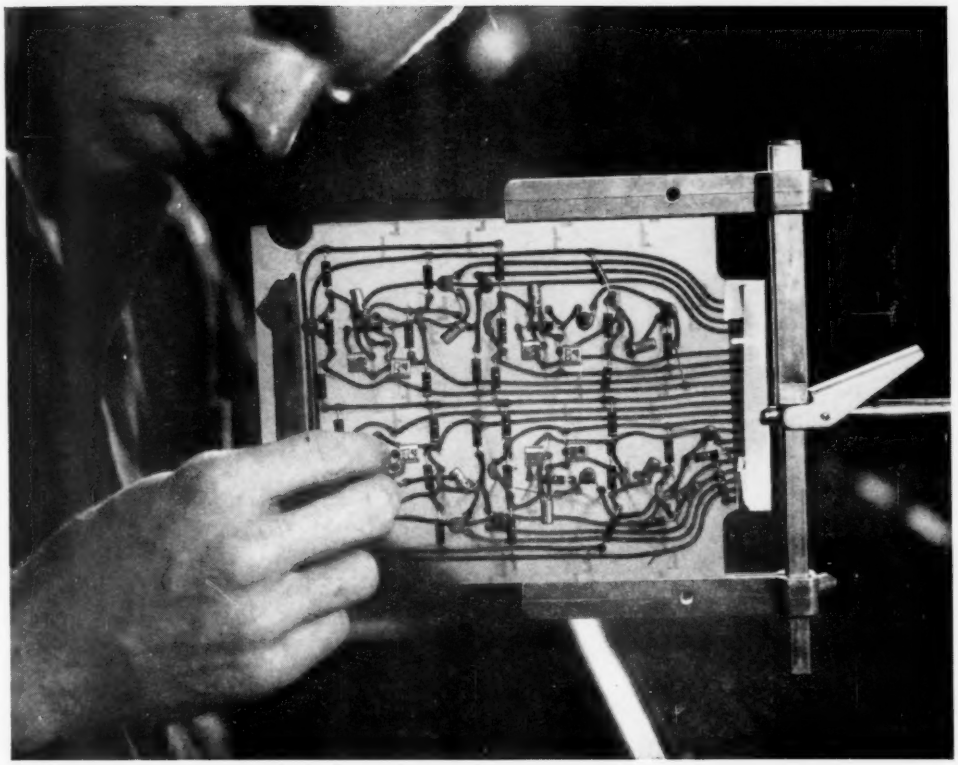
The National meeting provided a tremendous inspiration for those of us on the West Coast who cannot make the annual meetings routinely.

I am wondering if any of the committees are considering the possibility of regional American Speech and Hearing Association meetings? I, for one, would support this idea for I feel that we gain enough from the material presented to warrant its consideration.

Carmen C. Dixon
Chula Vista, California

CORRECTION: In the June issue of *Asha* we listed Katherine Snow as located at the University of Buffalo when she is an instructor at the Speech and Hearing Clinic, Indiana University, Bloomington, Ind.

Readers are urged to contact Walter Amster, VA Hospital, Coral Gables, Florida, Associate Editor of FORUM, if they have information pertinent to this Department.



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